VOLUNTARY - VISION PLAN ENROLLMENT FORM

Member Enrollment/Member Change Form

Anthem.

TO BE COMPLETED BY EMPLOYER		
Firm division no.	Health benefit plan	Requested effective date

Section 1. SUBSCRIBER/APPLICANT INFORMATION

Current Anthem BCBS contract no., if any	Last name	First name	M.I.

Home address or P.O. box	City	State	ZIP code

Home telephone	Work telephone	Marital status			
		☐ Single	☐ Legally separated	☐ Widowed	
		☐ Married	☐ Separated	☐ Divorced	

Section 2. ENROLLMENT REASON

☒ New group (initial enrollment) ☐ Annual enrollment ☐ New hire

☐ COBRA/CGS 38A-538: Reason _____ Qualifying event date _____

Section 3. CHANGE STATUS. PLEASE CHECK THE REASON(S) FOR CHANGE BELOW AND INDICATE DATE.

Type of change

☐ Name (indicate former name) _____ ☐ Address ☐ Other: Reason _____ Date _____

Section 4. MEMBERSHIP CHOICES

	Individual	Two person	Family
☐ Access Blue New England	☐	☐	☐
☐ BlueCare	☐	☐	☐
☐ Blue Choice New England	☐	☐	☐
☐ Century Preferred/PPO	☐	☐	☐
☐ Dental Plan name _____	☐	☐	☐
☐ HMO Blue New England	☐	☐	☐
☐ Lumenos HSA* Plan	☐	☐	☐
☐ Lumenos HRA Plan	☐	☐	☐
☐ Lumenos HIA Plan	☐	☐	☐
☐ Lumenos HIA Plus Plan	☐	☐	☐
☒ Blue View Vision Plan name _____	☐	☐	☐
☐ Other Plan name _____	☐	☐	☐

*Confirm with your employer which HSA custodian was selected.

Are you or any other eligible dependent listed on this form currently confined to a hospital or other health care facility, totally disabled or physically impaired?

☐ Yes ☐ No

Section 5. EMPLOYER INFORMATION

Company name **THE TOWN OF VERNON**

Are you actively at work?		Are you currently claiming Workers' Comp medical benefits?	
☐ Yes ☐ No If no, reason: ☐ Sick ☐ Injured ☐ Other _____		☐ Yes ☐ No	
Date of full-time hire*	Date of part-time hire*	Date of rehire* (if applicable)	Do you work 30 or more hours per week? ☐ Yes ☐ No Hours _____

*Date of hire/rehire: The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

Section 6. APPLICANT AND MEMBER INFORMATION (LIST ONLY FAMILY MEMBERS YOU WISH TO ADD OR CANCEL)

Add	Cancel	Vision	Name(s) of person(s) (Last name, first name, M.I.)	Sex	Birthdate (MM/DD/YYYY)	Full-time student age 19 or over?	Name of recognized institution for full-time students	Primary Care Physician (PCP) Name (Refer to Provider Directory or anthem.com) Put an X the box ☐ if you currently use this physician
☒	☐	☒	Self SSN	☐ M ☐ F				Name Not Applicable City ☐ PCP no.
☒	☐	☒	☐ Legal spouse ☐ Domestic partner SSN	☐ M ☐ F				Name Not Applicable City ☐ PCP no.
Children up to age 26 may be eligible. Please indicate if a child is a full-time student and circle disabled dependents.								
☒	☐	☒	Dependent SSN	☐ M ☐ F		☐ Yes ☐ No		Name Not Applicable City ☐ PCP no.
☒	☐	☒	Dependent SSN	☐ M ☐ F		☐ Yes ☐ No		Name Not Applicable City ☐ PCP no.
☒	☐	☒	Dependent SSN	☐ M ☐ F		☐ Yes ☐ No		Name Not Applicable City ☐ PCP no.

Section 7. PRIOR COVERAGE INFORMATION - THIS SECTION MUST BE COMPLETED.

Do you or any other member of your family have any other medical, dental, or Anthem Blue Cross and Blue Shield coverage?
☐ Yes ☐ No **If yes, please complete the following:**

	Self	Spouse/Domestic partner	Dependents 1	2	3
Name of insurance company	Not Applicable				
Certificate (policy) no.	Do NOT Complete				
First and last date of coverage					
Reason for termination					

Section 8. MEDICARE/MEDICAID INFORMATION

Do you or any covered member have Medicare/Medicaid coverage?
☐ Yes ☐ No

Have you or any covered member applied for Medicare/Medicaid disability?
☐ Yes ☐ No

Name(s) of Medicare Beneficiaries	Are you actively at work?	Retirement date (MM/DD/YYYY)	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date
Not Applicable						
Do NOT Complete						

Section 9. APPLICANT SIGNATURE

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

Applicant signature	Print name	Date
X		